Carlisle
DENTAL HYGIENE

PATIENT REGISTRATION

Prefix: ○ Dr. ○ Mr. ○ Mrs. ○ Ms. ○ Miss

Name: _____

Prefers to be called: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____

Business Phone: _____ Ext.: _____

Cell Phone: _____

E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex: _____

Marital Status: _____ Name of Spouse: _____

Are other family members patients with us? ○ Yes ○ No Name: _____

Where did you hear of us? ○ Google ○ Internet ○ Flyer ○ Other: _____

Family Physician: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Emergency Contact: _____ Phone: _____

PRIMARY DENTAL INSURANCE

Subscriber's Name _____ D.O.B. _____

Emp./Grp. policy holder _____

Ins. Co. _____ Tel. _____

Grp./Ind. policy No. _____ Cert. No. _____

I.D./S.I.N. _____

SECONDARY DENTAL INSURANCE

Subscriber's Name _____ D.O.B. _____

Emp./Grp. policy holder _____

Ins. Co. _____ Tel. _____

Grp./Ind. policy No. _____ Cert. No. _____

I.D./S.I.N. _____

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MEDICAL HISTORY SECTION

1. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

A.I.D.S.	○ Yes ○ No	Frequent headaches	○ Yes ○ No	Liver disease	○ Yes ○ No
Alcohol dependency	○ Yes ○ No	Frequent throat infections	○ Yes ○ No	Low blood pressure	○ Yes ○ No
Anemia	○ Yes ○ No	Glandular disorders	○ Yes ○ No	Lung disease	○ Yes ○ No
Angina pectoris	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lupus	○ Yes ○ No
Arthritis/rheumatism	○ Yes ○ No	Hay Fever	○ Yes ○ No	Malignant Hyperthermia	○ Yes ○ No
Artificial heart valve	○ Yes ○ No	Hearing difficulty	○ Yes ○ No	Medical implant	○ Yes ○ No
Artificial joints (hip, knee)	○ Yes ○ No	Heart attack	○ Yes ○ No	Mental/nervous disorder	○ Yes ○ No
Asthma	○ Yes ○ No	Heart disease	○ Yes ○ No	Metal allergies	○ Yes ○ No
Bleed or bruise easily	○ Yes ○ No	Heart murmur	○ Yes ○ No	Mitral valve prolapse	○ Yes ○ No
Blood disorders	○ Yes ○ No	Head/neck injuries	○ Yes ○ No	Organ transplant	○ Yes ○ No
Bronchitis	○ Yes ○ No	Heart pacemaker	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Cancer	○ Yes ○ No	Heart rhythm disorder	○ Yes ○ No	Psychiatric treatment	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Heart surgery	○ Yes ○ No	Radiation treatment	○ Yes ○ No
Circulation problems	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Rheumatic fever	○ Yes ○ No
Congenital heart lesions	○ Yes ○ No	Hepatitis B	○ Yes ○ No	Shortness of breath	○ Yes ○ No
Cortisone/steroid	○ Yes ○ No	Hepatitis C	○ Yes ○ No	Sickle cell disease	○ Yes ○ No
Crohn's disease	○ Yes ○ No	Herpes	○ Yes ○ No	Sinus trouble	○ Yes ○ No
Diabetes type I	○ Yes ○ No	High blood pressure	○ Yes ○ No	Skin rashes	○ Yes ○ No
Diabetes type II	○ Yes ○ No	H.I.V.	○ Yes ○ No	Smoking	○ Yes ○ No
Dramatic weight change	○ Yes ○ No	Hodgkins disease	○ Yes ○ No	Stomach problems	○ Yes ○ No
Drug dependency	○ Yes ○ No	Hyperglycaemia	○ Yes ○ No	Stroke	○ Yes ○ No
Emphysema	○ Yes ○ No	Hypoglycaemia	○ Yes ○ No	Swollen ankles/feet/hands	○ Yes ○ No
Epilepsy or seizures	○ Yes ○ No	Inflammatory bowel disease	○ Yes ○ No	Hyperthyroidism	○ Yes ○ No
Eyeglasses/contacts	○ Yes ○ No	Intestinal problems	○ Yes ○ No	Hypothyroidism	○ Yes ○ No
Fainting or dizzy spells	○ Yes ○ No	Jaundice	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Food allergies	○ Yes ○ No	Kidney disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Frequent earaches	○ Yes ○ No	Latex Allergies	○ Yes ○ No	Other _____	

PLEASE ANSWER THE FOLLOWING QUESTIONS:

2. Has the CHILD PATIENT recently had:
   Chicken pox ○ Yes ○ No
   Measles ○ Yes ○ No
   Strep throat ○ Yes ○ No
   Mumps ○ Yes ○ No
   Tonsillitis ○ Yes ○ No

3. **Women only:** Are you pregnant or suspect you may be? ○ Yes ○ No Expected delivery date? _____
   Are you breast feeding? ○ Yes ○ No Birth control pills? ○ Yes ○ No

4. Have you ever been hospitalized? If so, please detail for what: _____

5. When was your last visit to a physician? _____ Last complete physical? _____

6. Are you taking any medication? If so, please detail: _____

7. Are you allergic to any medication? If so, please detail: _____

8. Do you currently have, or had in the past, any disease, condition or problem not listed above? _____

_____

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DENTAL HISTORY SECTION

1. Is there a dental problem you would like treated immidiately? If so, please detail: _____

_____

2. Date of your last dental visit?_____ Last dental cleaning?_____ Last x-rays?_____

3. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

Bleeding gums	○ Yes ○ No	Emotional concerns for Dental treatment	○ Yes ○ No	Nail biting	○ Yes ○ No
Braces	○ Yes ○ No	Food catching between teeth	○ Yes ○ No	Painful gums	○ Yes ○ No
Chewing pain	○ Yes ○ No	Frequent bad breath	○ Yes ○ No	Root canals	○ Yes ○ No
Clenching appliance	○ Yes ○ No	Frequent biting of cheeks	○ Yes ○ No	Sensitive teeth to chewing	○ Yes ○ No
Clenching your teeth	○ Yes ○ No	Frequent biting of lips	○ Yes ○ No	Sensitive teeth to cold	○ Yes ○ No
Clicking jaw joint	○ Yes ○ No	Grinding your teeth	○ Yes ○ No	Sensitive teeth to sweets	○ Yes ○ No
Complication during or after dental treatment	○ Yes ○ No	Growths in your mouth	○ Yes ○ No	Shifted teeth	○ Yes ○ No
Dental implants	○ Yes ○ No	Gum surgery	○ Yes ○ No	Sore spots in your mouth	○ Yes ○ No
Difficulty opening	○ Yes ○ No	Jaw joint pain	○ Yes ○ No	Swollen gums	○ Yes ○ No
Difficulty closing	○ Yes ○ No	Jaw surgery	○ Yes ○ No	Wisdom teeth removed	○ Yes ○ No
Difficulty chewing	○ Yes ○ No	Loose teeth	○ Yes ○ No	Other _____	
				Other _____	

4. Have you been advised to take antibiotics before a dental appointment? ○ Yes ○ No

5. How often do you brush your teeth? _____

6. How often do you floss your teeth? _____

7. On a scale of 1 to 10 please rank your personal satisfaction with your oral health and smile _____

GENERAL RELEASE : TO BE SIGNED AT THE OFFICE

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical – dental history. Should there be any change in either my health status or any other information I have provided, I will advise Carlisle Dental Hygiene. I authorize Carlisle Dental Hygiene to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected used and disclosed within the guidelines of the policy.

I read, understand and agree to Carlisle Dental Hygiene cancellation policy.

I understand that Carlisle Dental Hygiene is owned and operated by an Independent Dental Hygienist and the only services available are preventative dentistry.
I authorize the dental staff to perform such preventative dental services as may be necessary and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company.

I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these service. I understand that Carlisle Dental Hygiene will make one attempt to direct bill my insurance for payment of dental services. If my claim is unable to be processed and/or no payment is issued, I understand that I am personally responsible for payment of all dental services rendered within 30 days from the day of treatment.

_____ _____

(signature) Patient ☐ Parent ☐ Guardian ☐ (print name of guardian)

Reviewed by: _____ Date: _____